STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155727	A. BUILDING _____ B. WING _____	R 07/10/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
STONEBRIDGE HEALTH CAMPUS	**3100 SHAWNEE DR S BEDFORD, IN 47421**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
{F 000}	INITIAL COMMENTS	{F 000}		

This visit was for the Post Survey Revisit (PSR) to the Recertification and State Licensure Survey completed on 05/17/12.

This visit was in conjunction to the investigation of Complaint IN00111423.

Survey dates: 07/09/12 and 07/10/12

Facility number: 003924
Provider number: 155727
AIM number: 200472040

Survey team:
Sharon Whiteman RN TC
Susan Worsham RN

Census bed type:
SNF: 11
NF: 45
Residential: 36
Total: 92

Census payor type:
Medicare: 21
Medicaid: 24
Other: 47
Total: 92

Sample: 11

Stonebridge Health Campus was found to be in compliance with 42 CFR, Part 483, Subpart B and 410 IAC 16.2 in regard to the PSR to the Recertification and Licensure Survey.

Quality review completed 7/11/12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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{F 000}	Continued From page 1 Cathy Emswiller RN	{F 000}		